

***Federal Fiscal Year 2001
FRAMEWORK FOR ANNUAL REPORT
OF STATE CHILDREN'S HEALTH INSURANCE PLANS
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT***

Preamble

Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist states in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with states to develop a framework for the Title XXI annual reports.

The framework is designed to:

- ❖ Recognize the ***diversity*** of State approaches to SCHIP and allow States ***flexibility*** to highlight key accomplishments and progress of their SCHIP programs, **AND**
- ❖ Provide ***consistency*** across States in the structure, content, and format of the report, **AND**
- ❖ Build on data ***already collected*** by CMS quarterly enrollment and expenditure reports, **AND**
- ❖ Enhance ***accessibility*** of information to stakeholders on the achievements under Title XXI.

*Federal Fiscal Year 2001
FRAMEWORK FOR ANNUAL REPORT
OF STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER
TITLE XXI OF THE SOCIAL SECURITY ACT*

State/Territory: Massachusetts
(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

(Signature of Agency Head)

SCHIP Program Name(s): MassHealth

SCHIP Program Type:
☐ Medicaid SCHIP Expansion Only
☐ Separate SCHIP Program Only
☒ Combination of the above

Reporting Period: Federal Fiscal Year 2001 (10/1/2000-9/30/2001)

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Submission Date: December 31, 2001

(Due to your CMS Regional Contact and Central Office Project Officer by January 1, 2002) Please cc Cynthia Pernice at NASHP (cpernice@nashp.org)

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SECTION 1. DESCRIPTION OF PROGRAM CHANGES AND PROGRESS

This sections has been designed to allow you to report on your SCHIP program changes and progress during Federal fiscal year 2001 (September 30, 2000 to October 1, 2001).

1.1 Please explain changes your State has made in your SCHIP program since September 30, 2000 in the following areas and explain the reason(s) the changes were implemented.

Note: If no new policies or procedures have been implemented since September 30, 2000, please enter "NC" for no change. If you explored the possibility of changing/implementing a new or different policy or procedure but did not, please explain the reason(s) for that decision as well.

- A. Program eligibility: NC
- B. Enrollment process: NC
- C. Presumptive eligibility: NC
- D. Continuous eligibility: NC
- E. Outreach/marketing campaigns

An important component of outreach activities has been the Division of Medical Assistance's (the Division's) collaborative effort with Community-Based Organizations (CBOs) through its Massachusetts Projects for Health Access and Outreach Services "Mini-grant" Initiative. The CBOs include health centers, hospitals, schools, and a variety of human service organizations. The June 2000 procurement resulted in FY01 outreach mini-grant awards to Eighty-four organizations for the period July 1, 2000 to June 30, 2001. The Twelve-month funding amount ranged from \$10,000 - \$15,000 per mini-grant site. The total allocation for the Health Care Access and Outreach Services Projects was \$1.2 million.

The School Nurse Initiative continued in FY01 as the Division, in partnership with the Department of Public Health (DPH), worked closely with the school nurses throughout Massachusetts and their professional association to promote MassHealth. The initiative helps disseminate information, identify uninsured children, and provide enrollment assistance. School Nurse MassHealth Enrollment promotional kits were distributed during FY01. These kits contained travel mugs with an inscription recognizing school nurses for their efforts in helping school children enroll in MassHealth, and a guidebook highlighting all health programs in the state, including MassHealth and the state-funded Children's Medical Security Plan (CMSP).

Massachusetts is a Robert Wood Johnson Foundation Covering Kids' site. The

Division works closely on this initiative with the Director of the Massachusetts Covering Kids program, located at Health Care for All, a health advocacy group in Boston. There is active collaboration between the two organizations, with shared enrollment and outreach activities. Several joint initiatives have been undertaken as part of the Massachusetts Covering Kids initiative. Eleven schools have been identified as Covering Kids pilot sites in Massachusetts and are actively working with Health Care for All and the Division to identify ways to reach children and get them enrolled in MassHealth. In FY01, these pilot sites initiated a change in their free and reduced price meal application to include a question that asked parents or guardians if they would like more information on free or low-cost health insurance. Several models were set-up to reach and assist families who requested this information. In some schools, the school nurses were leading the program and doing follow-up. In other programs, local community agencies were given that responsibility.

The Division continues to work closely with the Massachusetts Hospital Association (MHA), the Massachusetts Medical Society (MMS), and the Massachusetts Chapter of the American Academy of Pediatrics (AAP) to promote the state's MassHealth program. Providers' front office and billing staff are encouraged to participate in regional training sessions through direct mail and organizational publications. Additionally, MassHealth enrollment kits, "What to Do When an Uninsured Child Shows up at Your Door", were widely distributed. In FY01, the MHA and Massachusetts League of Community Health Centers were both given outreach contracts from the Division to support media and other efforts to reach potentially eligible MassHealth members and encourage them to apply for benefits.

F. Eligibility determination process

In compliance with the final SCHIP regulations, the Division no longer requires non-applying family members provide their Social Security Numbers to MassHealth. There is currently a manual procedure in place to allow processing of an MBR without the Social Security Number of a non-applying family member. The Medical Benefit Request (MBR) form will be revised in FY02 to reflect this change.

G. Eligibility re-determination process

MassHealth Member Express Renewal Pilot Project - Improving MassHealth Retention through Point of Service Re-enrollment: Under Express Renewal, a MassHealth provider may assist a member in submitting a re-enrollment application when the MassHealth member visits a provider within 6 months of their re-determination date. The member completes a simplified re-enrollment form and may self-declare family income. If the re-enrollment application is approved, the member's next renewal date will be twelve months from the date of re-determination. This pilot study is funded by a grant from CMS and may apply

to some children for whom the state receives Title XXI funding. The federal grant was for the federal fiscal year beginning October 1, 2000 and continuing, via an approved extension, until January 31, 2002.

H. Benefit structure: NC

I. Cost-sharing policies

In compliance with final SCHIP regulations, the Division no longer requires premium payments by members of a federally recognized Native American tribe or Alaskan Natives. There is currently a manual process in place to stop premiums from being calculated. Automation of this change in our eligibility system and a change to the MBR is planned for FY02.

J. Crowd-out policies: NC

K. Delivery system: NC

L. Coordination with other programs (especially private insurance and Medicaid): NC

M. Screen and enroll process: NC

N. Application: NC

O. Other: NC

1.2 Please report how much progress has been made during FFY 2001 in reducing the number of uncovered low-income children.

A. Please report the changes that have occurred to the number or rate of uninsured, low-income children in your State during FFY 2001. Describe the data source and method used to derive this information.

The Division continues to monitor surveys that measure the rate of uninsurance in Massachusetts. As stated in last year's SCHIP report, results from the year 2000 survey conducted by the Division of Health Care Finance and Policy (DHCFP) showed a decline in the number of uninsured in Massachusetts from 8.2% of the population in 1998 to 5.9% in 2000. The rate of uninsured declined in every age-category, and for children less than 18 years of age the rate of uninsurance dropped from 5.8% in 1998 to 2.8% in 2000. DHCFP intends to re-survey during 2002.

Likewise, last year's Urban Institute's National Survey of American Families (NSAF) showed a decrease in the number of uninsured children in

Massachusetts of 6.7% to 3.4% from 1997 to 1999. For children in families with incomes below 200% of the federal poverty level, there was a decrease from 13.8% to 6.5% for the same time period.

The Current Population Survey (CPS) March Supplement also provides information on trends in health insurance status for the population in Massachusetts. It has consistently reported a higher rate of uninsurance than our own surveys. In March 2001, CPS reported that 10.4% of children (ages 0 to 18) were uninsured in Massachusetts.

- B. How many children have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information.

Massachusetts continues to operate its SCHIP program in conjunction with its Medicaid Program and Demonstration Waiver under Section 1115. All programs, including SCHIP, are called MassHealth. A single application is used for these programs. Efforts to streamline and simplify the application form to be used for MassHealth had begun under the Division's 1115 Demonstration Waiver prior to the enactment of Title XXI. The importance of the efforts that were underway under the 1115 waiver were amplified with passage of SCHIP, and Massachusetts' efforts to enhance its enrollment, outreach, and marketing efforts have resulted in an increased number of children brought into the combined MassHealth effort.

For example, the Division's data indicates that in June 1997 there were 305,832 children enrolled in MassHealth. As of September 30, 2001 there were 418,436 children in MassHealth. (See section 3.1C).

- C. Please present any other evidence of progress toward reducing the number of uninsured, low-income children in your State.

As reported last year, Massachusetts ranked second best among all states in its average monthly progress in enrolling eligible children for health insurance coverage under SCHIP and Medicaid combined. The Children's Defense Fund calculated this ranking based on setting a target number of uninsured children for each state (those uninsured children in the state at or below 200% of FPL), and then calculating the states' average monthly rates of progress toward covering the target number. States were then ranked from highest to lowest by their monthly progress rates.¹ A state-by-state comparison of the estimated percentage of uninsured children by the Children's Defense Fund during the years 1997-1999, using CPS data, shows Massachusetts with 8.7% of its children under 19 uninsured, ranking it seventh among states. (States are

¹ "All Over the Map – A Progress Report on the State Children's Health Insurance Program" Children's Defense Fund, Washington, D.C. July, 2000

ranked by lowest percentage of uninsured children.)¹

Massachusetts has continued its progress in enrolling children in MassHealth, as evidenced by a 6.8% increase in children enrolled between September 30, 2000 and September 30, 2001.

- D. Has your State changed its baseline of uncovered, low-income children from the number reported in your March 2000 Evaluation?

 X No, skip to 1.3

 Yes, what is the new baseline?

What are the data source(s) and methodology used to make this estimate?

What was the justification for adopting a different methodology?

What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

Had your state not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

¹ "Uninsured Children Under Age 19 in the States, 1999" (revised November 2, 2000).
www.childrensdefensefund.org.

1.3 Complete Table 1.3 to show what progress has been made during FFY 2001 toward achieving your State's strategic objectives and performance goals (as specified in your State Plan).

In Table 1.3, summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

- Column 1: List your State's strategic objectives for your SCHIP program, as specified in your State Plan.
- Column 2: List the performance goals for each strategic objective.
- Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator and denominator). Please attach additional narrative if necessary.

Note: If no new data are available or no new studies have been conducted since what was reported in the March 2000 Evaluation, please complete columns 1 and 2 and enter "NC" (for no change) in column 3.

- 1.4 If any performance goals have not been met, indicate the barriers or constraints to meeting them.**
NC
- 1.5 Discuss your State's progress in addressing any specific issues that your state agreed to assess in your State plan that are not included as strategic objectives.**
N.A.
- 1.6 Discuss future performance measurement activities, including a projection of when additional data are likely to be available.**

Enrolling children in MassHealth and delivering high quality care to them is of critical importance to the Division. Following are examples of some of the activities the agency is involved in to monitor our efforts on behalf of children's health.

Tools, initiatives and educational messages were developed to support the PCCs and the Division's contracted managed care organizations in their efforts to improve management of children with asthma. Some of the activities developed to support asthma improvement during FY01 include:

Asthma Pre-Visit Questionnaire: This is a one-page questionnaire developed as a tool for the PCC to assess a member's asthma status immediately prior to their visit with the PCC.

Asthma Flow Sheet: This is a one-page check sheet for the PCC to use when an Asthma patient comes in for each visit. It includes various topics related to Asthma treatment, referrals, and member education.

The Division is a member of the Massachusetts Health Quality Partnership (MHQP). In September 2001 the MHQP and representatives from 21 Massachusetts health care organizations joined together to endorse an initiative to promote a key component of best practices in the management of pediatric asthma. The group developed the written Asthma Action Plan form to assist clinicians and members in the management of asthma. The form was made available free of charge in multiple languages.

In addition the MHQP has endorsed the DPH's Massachusetts Immunization Program (MIP) for the second year. MHQP distributed the immunization guidelines and recommended childhood schedule along with the distribution of its Pediatric Preventive Care Recommendations. The PCC Plan and the DPH joined together to increase the rate at which adolescents have an annual well-child care visit and thereby increase the opportunities that providers have to deliver age appropriate anticipatory guidance. As part of its strategy, the MassHealth Adolescent Anticipatory Guidance Public Awareness Campaign

(MAGPAC) committee plans to develop a statewide public awareness campaign promoting the importance of preventive care for adolescents.

The Division also participates in the Government Performance Results Act (GPRA), a CMS-sponsored multi-year initiative to improve immunization rates for two year olds. In September 1999, the Division submitted baseline information derived from its HEDIS 1998 Report on the immunization status of MassHealth two-year-olds enrolled in the PCC Plan and the Division's contracted MCOs. In January 2001, the Division submitted to CMS its interim measurement based on its HEDIS 2000 results.

The PCC Plan and the Division's MCOs will jointly be sending a publication to providers outlining what providers can do to address missed opportunities in childhood immunizations with the potential for a series of articles in the future highlighting other barriers to childhood immunization. Both the MIP, through its Immunization Assessments, and Center for MassHealth Evaluation and Research (CMER), through its Clinical Topic Review for the MCO Program, identified similar areas for improvement. The MIP and CMER staff jointly produced a document that delivers a universal message for MassHealth providers about the root causes of missed opportunities in vaccine administration and strategies to address these issues. In FY02, the PCC Plan, the Division's MCOs, the MIP, and CMER will finalize the universal message and distribute the article to its provider networks. The group will also evaluate the success of the initial article and determine the potential success of a series of articles on additional topics.

The Division recognizes the importance of delivering quality health care to young mothers, who may be eligible for SCHIP. The Perinatal Care Quality Improvement Project (PQIP) is structured to implement activities in a coordinated manner across both the PCC Plan and the MCO Program in order to maximize the care received by this special group. Accordingly sub goals have been identified, with specific activities undertaken in their support. Some of the activities are described below.

The PQIP developed a tri-fold colorful guide featuring four key messages. The first was to get early prenatal care and that proper nutrition was vital to making sure you have a healthy baby. The second message was to take a vitamin with folic acid every day. The third was not to smoke, drink alcohol, or use drugs during pregnancy. The fourth message told them to protect themselves and their children from domestic violence. The pamphlet includes help-line numbers allowing women to seek more information. An English and Spanish version of the brochure is currently available. The MassHealth Customer Service Center is currently distributing this material to all pregnant women or members with a pregnant family member applying for MassHealth, including those pregnant women for whom the state receives funding through SCHIP

The Division also played a key role in the development of the MHQP Perinatal Guidelines and the Risk Assessment Form. Both instruments contain new psychosocial risk assessments. Currently these materials are being refined.

1.7 Please attach any studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program's performance. Please list attachments here.

The Division contracted with CMER at the University of Massachusetts Medical School to conduct an evaluation of the effectiveness of the Presumptive Eligibility (PE) and the Family Assistance Direct Coverage policies. Both evaluations appear in the same report. (See Attachment A).

Goals of the PE project included identifying if children moved from PE into either Standard or Family Assistance, what costs may have been incurred during the 60 day period, and whether members understand what PE means in terms of coverage.

The Family Assistance Direct Coverage evaluation goals were to assess the impact of premium payments on the continuity of coverage for children enrolled in MassHealth through Family Assistance Direct Coverage, and to evaluate the Division's process of communication with members regarding premium collection.

The Division has also contracted with CMER to evaluate the redetermination process. The goals of the evaluation were to assess the trend in non-response rates, determine the factors that may enhance or detract from the redetermination process through interviews, and compare Massachusetts's redetermination strategies and response rate to that of other states. (Report in process.)

SECTION 2. AREAS OF SPECIAL INTEREST

This section has been designed to allow you to address topics of current interest to stakeholders, including; states, federal officials, and child advocates.

2.1 Family coverage:

- A. If your State offers family coverage, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other program(s). Include in the narrative information about eligibility, enrollment and redetermination, cost sharing and crowd-out.

N.A.

- B. How many children and adults were ever enrolled in your SCHIP family coverage program during FFY 2001 (10/1/00 - 9/30/01)?

_____ Number of adults

_____ Number of children

- C. How do you monitor cost-effectiveness of family coverage?

2.2 Employer-sponsored insurance buy-in:

- A. If your State has a buy-in program, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP program(s).

As part of both its 1115 Demonstration Waiver and SCHIP, MassHealth introduced a buy-in program to provide assistance toward employer sponsored insurance (ESI). The primary population are those eligible for MassHealth Family Assistance¹. Family Assistance provides coverage to children in families with income greater than 150% but not more than 200% of the FPL. In order to receive benefits through MassHealth, eligible children are required to enroll in ESI if their family has access to a qualified plan. An ESI plan is qualified if the employer pays at least 50% of the premium, a cost effectiveness standard is met, and the benefit package meets the Basic Benefit Level. Under Family Assistance Premium Assistance, MassHealth pays the employee's share of the premium (with the family remaining responsible for \$10 per child up to \$30 per month). If premium assistance is provided to a child who was uninsured at the time of application and the employer's plan meets the Title XXI Benchmark Benefit Level requirement, coverage is provided through Title XXI.

¹ Certain MassHealth Standard and CommonHealth members may also receive assistance towards the purchase of ESI.

If the child does not have access to health insurance that meets the Division's 1115 Waiver or Title XXI requirements, then the child is enrolled in MassHealth Family Assistance Direct Coverage (as a SCHIP child).

In most cases, by providing premium assistance toward ESI on behalf of an eligible child, parents and other family members also gain health insurance coverage through the employer plan at no additional cost to the Division. These additional covered lives are not included in the MassHealth enrollment numbers.

- B. How many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2001?

NA Number of adults

700 Number of SCHIP children receiving Premium Assistance that were enrolled on Sept. 30, 2001.

2867 Number of children receiving Premium Assistance who were uninsured at time of enrollment [includes 700 SCHIP children] and were enrolled on Sept. 30, 2001.

5812 Total number of MassHealth children receiving Premium Assistance who were enrolled on Sept. 30, 2001 [whether or not insured or uninsured at time of enrollment].

2.3 Crowd-out:

- A. How do you define crowd-out in your SCHIP program?

Crowd-out would occur if employees dropped coverage in ESI in order to obtain MassHealth Direct Coverage. However, under MassHealth rules, access to ESI is investigated as part of the eligibility determination process and applicants with access are required to enroll in their employer's coverage. Because enrollment in ESI is required for those with access, potential for crowd-out is diminished. Massachusetts requires a family that has access to ESI to purchase it with the help of a MassHealth Premium Assistance payment. If the family does not enroll in the ESI, the child will not receive any benefits from MassHealth. If families do not have access, then the child is placed in the Direct Coverage group.

Crowd-out may also occur if employers began to lower the amount of contribution or stop offering the coverage all together because of the program. (At this time there is no evidence that either of these has happened.)

- B. How do you monitor and measure whether crowd-out is occurring?

As mentioned in last years report the DHCFP monitors the rate of crowd-out by analyzing a variety of survey data including the US Bureau of Census data. Massachusetts is one of 11 states funded by the Health Resources and Services Administration (HRSA) to collect and analyze data to use in developing an insurance profile of the state. The profile assesses health insurance coverage from a number of perspectives including those of employers and residents. In addition, the data will look at take up rates, demographics, and employer thinking on issues such as tiers of coverage, and whether coverage is available for families or only the employee. It is expected that this information will help states develop options and recommendations about steps and initiatives that could lead to universal health coverage. The grant period has been extended for six months and a final report will be available in the Spring of 2002. Preliminary results from the report indicate that over 78% of eligible employees enroll in their ESI. In addition, almost 86% of employers reported that the number of employees enrolling in ESI has remained constant over the past few years, 9.8% reported more employees enrolled, and only 4.3% reported a decline in enrollment. These measures help the Division to monitor crowd-out.

- C. What have been the results of your analyses? Please summarize and attach any available reports or other documentation.

The HRSA report will be completed in 2002.

- D. Which anti-crowd-out policies have been most effective in discouraging the substitution of public coverage for private coverage in your SCHIP program? Describe the data source and method used to derive this information.

It is a requirement that anyone with access to ESI, enroll in ESI, making it near impossible for crowd-out to occur in MassHealth. In addition, the Division's provision of an incentive payment to qualified small employers under the Insurance Partnership encourages employers to begin providing or to continue to provide coverage to low-income employees.

2.4 Outreach:

- A. What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness?

Massachusetts continues to apply a multi-pronged approach for the outreach activities targeting low-income uninsured children. This strategy has helped to increase membership in MassHealth and to decrease the number of uninsured children in the state. The following is a description of some of the

outreach activities, which have been successful.

Marketing and Outreach to linguistically and culturally diverse populations through TV, radio, and print materials helps to disseminate information about health coverage for children under MassHealth. Some of the media materials have been translated to target groups such as the Latino, Portuguese, and Chinese populations and have been effective in increasing enrollment for children among these groups.

The Division continues its school-based outreach activities for children, including distribution of a MassHealth Informational Flyer. For five years, the Division has sent a one-page MassHealth informational flyer to approximately 1.5 million children enrolled in child care settings, public, private, and parochial schools in the state. The one page flier provides MassHealth and CMSP information in English and Spanish.

Another school-based outreach activity is the School Nurse Initiative. The Division, in partnership with the DPH, works closely with the school nurses throughout Massachusetts and their professional association to promote MassHealth. The initiative helps disseminate information, identify uninsured children, and provide enrollment assistance.

Other school outreach activities include the following: active review of a child's health insurance status at appropriate opportunities, such as kindergarten registration, or at the time a child transfers into a school; routine inclusion of information about MassHealth and the CMSP in school publications; and a school newsletter providing MassHealth information and resources for school staff and school nurses.

Massachusetts is a Robert Wood Johnson Foundation Covering Kids' site. The Division works closely on this initiative with the Director of the Massachusetts Covering Kids program, located at Health Care for All, a health advocacy group in Boston. There is active collaboration between the two organizations, with shared enrollment and outreach activities. Several joint initiatives have been undertaken as part of the Massachusetts Covering Kids initiative:

- School Pilot Sites: Eleven schools have been identified as Covering Kids pilot sites in Massachusetts and are actively working with Health Care for All and the Division to identify ways to reach children and get them enrolled in MassHealth. In FY01, these pilot sites initiated a change in their free and reduced price meal application to include a question that asked parents or guardians if they would like more information on free or low-cost health insurance. Several models were set-up to reach and assist families who requested this information. In some schools, the school nurses were leading the program and doing follow-up. In other programs, local community agencies were given

that responsibility.

- Nutrition: Nutritionists from the 11 schools sites around the state are working to get MassHealth information out when nutritional information is sent to parents.

The Division continues to work closely with the MHA, the MMS, and the Massachusetts Chapter of the AAP to promote the state's MassHealth program. Provider's front office and billing staff are encouraged to participate in regional training sessions through direct mail and organizational publications. Additionally, MassHealth enrollment kits ("What to Do When an Uninsured Child Shows up at Your Door") were widely distributed. In FY01, the MHA and Massachusetts League of Community Health Centers were both given outreach contracts from the Division to support media and other efforts to reach potentially eligible MassHealth Members and encourage them to apply for benefits.

- B. Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness?

The Outreach-Mini-Grant Program appears to have contributed substantially to enrollment. Major accomplishments of the program include: 1) collaboration that has occurred between the Division and DPH to improve health care access for people of the Commonwealth, 2) the bridges that have been built between the two state agencies and CBOs to establish a partnership that implements the Outreach Mini-Grant Program at the community level, and 3) considerable activity and effort that has been brought about to inform communities about MassHealth and CMSP, and to provide assistance to individuals and families on eligibility, enrollment and maintenance of coverage.

Through the mini-grant initiatives, the Division has found local efforts are an important component of an effective outreach strategy to reach eligible children. The key to success in working through local efforts is using strategies that are effective in the context of the targeted community. A few of the effective local strategies being pursued are highlighted below.

Collaboration in the City of Lynn: The Lynn Public School System's aggressive outreach campaign to ensure that all children in Lynn have health insurance is an example of a successful system wide initiative that builds on internal and external collaborations.

- Parent Information Center: Working through the Parent Information Center, where all new and transferring students must register, as the primary internal collaborator, insurance information is requested at the time of registration and referrals for those without health insurance are

given to the school nurses. The nurses also receive information on uninsured students from the student/parent emergency forms, and since September 2000, the School Lunch Program form (for free or reduced lunches) includes insurance information. In addition, school nurses frequently conduct home visits to families needing more information about available or low cost health insurance and application assistance.

- **External Collaborators:** The primary external collaborator is the Lynn Community Health Center, which operates eight School Based Health Centers (SBHC) funded by the DPH. The SBHC staff works closely with school nurses to identify students in need of primary care. Other external collaboration is provided through a mobile van operated by the North Shore Medical Center that offers information on health insurance in addition to providing access to care on a neighborhood basis. The Lynn Public School System has developed a close relationship with Community Development and Lynn Parks and Recreation. School nurses attend many sports and other community events, and coaches and other group leaders often refer youth they deem in need of insurance follow-up to the school nurses.
- **Partners:** The Mayor of Lynn has been a primary partner for Lynn Public Schools, initiating the insurance outreach program and other efforts such as the “Gold Card” program. The Gold Card program offers Lynn’s youth free or reduced memberships to the Boys & Girls Club, YMCA and Gregg House, and health insurance information is requested on the Gold Card application and forwarded to the Lynn Public Schools.

Joint Committee for Children's Health in Everett: The Joint Committee targets low-income children and families in Malden and Everett. The population is largely Vietnamese and Haitian-Creole so that bilingual Outreach Workers staff are available and materials are translated into those languages (including MassHealth booklets). In addition, TV ads and ads in the community newspapers are run which announce upcoming events. Meetings are also held at local schools and the pre-school’s Parent Teacher Organization meetings to inform attendees about MassHealth eligibility and how to retain eligibility. They also participated in the free and reduced lunch pilot program as mentioned in Section 1.1 E.

Outer Cape Health Services: Eight communities on the Cape participated in the Family Fun Fair where a MassHealth information table was set up. There were puppet shows, raffles and giveaways, which were held at the local libraries. Also, school nurses and principals distributed fliers, brochures and applications at special school events at local elementary

schools.

Ecu-Health Care Inc in North Adams: Ecu-Health Care Inc. serves a large rural low-income population of children to age 19 and pregnant women. Ecu-Health Care Inc. also markets to uninsured families of North Berkshire disseminating information on how to access all available MassHealth programs. A combination of radio and print media campaigns have generated high responses from families now enrolled with MassHealth or CMSP. 400-600 MassHealth ads are run on local access channels and cable television every month. The local Mayor and Senator Kennedy also record local advertisements promoting MassHealth programs.

Somali Development Center, Jamica Plain: The center targets uninsured Somali refugees and their children for MassHealth and CMSP programs. There is a large Somalian population in the Boston area that receive interpreter and translation services to help them overcome linguistic, cultural and economic barriers to accessing quality health care. Over 70 percent of the three to five thousand Somali refugees settling in the Boston area since 1993 are single women with children from middle to high school age. 150 Somali children and families were enrolled in MassHealth or CMSP in FY01. Public service announcements are run weekly in Somali on local access television. The Center has an extensive youth program which integrates information about MassHealth and CMSP into its life-skills after school program. These students help distribute MassHealth materials to local Somali families in their communities.

Codman Square Health Center: The nutritionist at the health center gave a "community baby shower" for new mothers, and the mini-grant outreach program was invited to set up a table and participate in the event. The outreach worker commented: "It was wonderful. I was able to get to know the needs of the mothers and make connections for follow-up. The best part was holding all of the babies." In addition to the baby shower, Codman Square also actively promotes its services and information about MassHealth in local newspapers, has translated its promotional and screening materials into Spanish and Haitian Creole, and has found that posters with tear-off sheets in community stores produce an excellent response.

The Outreach-Mini-Grant Evaluation, conducted by CMER, used monthly activity reports and also site visits of a representative cross-section of mini-grantees to identify program accomplishments and opportunities for improvement in the areas of outreach and marketing, enrollment, retention, and renewal of enrollees. (See attachment B.)

- C. Which methods best reached which populations? How have you measured effectiveness?

Massachusetts continues to use multiple methods to reach uninsured children.

2.5 Retention:

- A. What steps are your State taking to ensure that eligible children stay enrolled in Medicaid and SCHIP?

As part of its redetermination process, the Division uses an automated system to send renewal notices to all MassHealth members. Every week 5,000 households, whose review date has passed, are selected and the system generates a cover letter. The letter informs the members that the new eligibility review verification (ERV) from is due 65 days from the date of the original renewal notice. A package is sent to the households which includes the renewal notice, an ERV form, bilingual instruction sheet on how to fill out the form or where to get help, a multi-language translation sheet in 14 different languages telling people to get the ERV translated, and a self-addressed stamped envelope. Once the new ERV has been received by the Division, a new review date is generated a year from the processing date. If a section of the ERV is unclear, the Division calls the household to clarify any information.

Currently the MA21 automated system checks to see which ERVs have not been returned by the 35th day. The system then generates a reminder notice with the original due date. If the ERV has not been received by the 50th day the system sends a second reminder notice. If the ERV has not been received by the 65th day a closing notice is sent to the household with a case closing date. After the closing notice is sent, the Division allows the MassHealth member 14 days to respond. Persons who complete their ERV following the closure of the case, may have their case reopened as of the date of submission of the completed ERV, if otherwise eligible to receive benefits.

The Division also provides the MCOs with a list of their members who will be up for renewal. In addition, the outreach workers can access information online to see if someone might be up for renewal and can assist him or her with the review process.

In addition, as discussed in Section 1.1H, the Division is piloting its Express Renewal Pilot Project.

- B. What special measures are being taken to re-enroll children in SCHIP who disenroll but are still eligible?

- ☒ Follow-up by caseworkers/outreach workers
- ☒ Renewal reminder notices to all families
- ☒ Targeted mailing to selected populations, specify population (this is done by mini-grantees)
- ☒ Information campaigns
- ☒ Simplification of re-enrollment process, please describe (see section A above on MassHealth Member Express Renewal Pilot Project.)
- ☐ Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, please describe
- ☐ Other, please explain

C. Are the same measures being used in Medicaid as well? If not, please describe the differences.

YES

D. Which measures have you found to be most effective at ensuring that eligible children stay enrolled?

As described in Section A above, the Division's inclusion of self-addressed stamped envelopes and use of reminder letters when ERVs are not returned at certain points in time have been helpful in ensuring eligible children remain enrolled.

The Division continues to refine its redetermination process to ensure that members are only reviewed when necessary. For example, the Division now reviews members to see if they are eligible under other categories, such as SSI, and does not require those members to complete an ERV. A change implemented in FY01 includes identifying maintenance MBRs and treating them as an Eligibility Review rather than as a new application. This change therefore rolls the member's date of redetermination to a year from that date.

E. What do you know about insurance coverage of those who disenroll or do not re-enroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured?) Describe the data source and method used to derive this information.

As stated in last year's report, we do not have specific data on the insurance coverage status of SCHIP children who disenroll or who do not re-enroll in SCHIP. However, for MassHealth in general there is a trend that within 6 months of disenrolling the majority of former MassHealth members come back into MassHealth.

2.6 Coordination between SCHIP and Medicaid:

- A. Do you use common application and redetermination procedures (e.g., the same verification and interview requirements) for Medicaid and SCHIP? Please explain.

MassHealth is one program that encompasses both Medicaid and SCHIP. Applications and redetermination procedures are the same for all children who apply for or enroll in MassHealth.

- B. Explain how children are transferred between Medicaid and SCHIP when a child's eligibility status changes.

MassHealth's automated eligibility system (MA21) ensures a child is placed in the richest benefit group for which the child is eligible.

- C. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.

There is no distinction between delivery systems used in Medicaid and SCHIP.

2.7 Cost Sharing:

- A. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

As mentioned in section 1.7, the Family Assistance Direct Coverage Evaluation goals were to assess the impact of premium payments on the continuity of coverage for children enrolled in MassHealth through Family Assistance Direct Coverage, and to evaluate DMA's process of communication with members regarding premium collection.

Preliminary findings from this study found that decision making around paying premium is multi-faceted involving several factors which include: competing household costs and general affordability of the payment required, family's concept of public assistance and/or prior experience with MassHealth, the way a family receives and interprets information from DMA, and the way the Division handles billing. (See Attachment A.)

- B. Has your State undertaken any assessment of the effects of cost-sharing on utilization of health service under SCHIP? If so, what have you found?
No.

2.8 Assessment and Monitoring of Quality of Care:

- A. What information is currently available on the quality of care received by SCHIP enrollees? Please summarize results.

As a MassHealth member, SCHIP eligible children without access to ESI are required to enroll in managed care through the Division's Primary Care Clinician (PCC) Plan or one of the contracted Managed Care Organizations (MCOs) in order to receive health care services. Quality of health care is measured by various means. The Division incorporates specific quality standards into its MCO contracts and also applies HEDIS measures to all managed care plans, including the PCC Plan, to assess clinical quality (sometimes these are assessments of process or assessments of utilization).

The Division also conducts an annual MassHealth Member Survey for the purpose of eliciting member feedback in a number of areas including availability and access to services, utilization and experience with health services, as well as member satisfaction with the services delivered by their health plan or provider. The most recent MassHealth Managed Care Member Survey (2000-2001) was conducted for the Division by the Center for Survey Research (CSR) at the University of Massachusetts (Boston). The member survey was conducted using the CAHPS instrument with additional questions identified by the Division.

A special emphasis of this year's MassHealth Member survey was to describe the experiences of children enrolled in MassHealth who have special health care needs. As a result, the sample was expanded and the survey instrument included questions designed to measure issues of special relevance to those children and their families. A total of 3772 surveys were returned for an overall response rate of 54%. The results for this year's survey are not yet available. (See attachment C for survey instrument.)

- B. What processes are you using to monitor and assess quality of care received by SCHIP enrollees, particularly with respect to well-baby care, well-child care, immunizations, mental health, substance abuse counseling and treatment and dental and vision care?

Participation in GPRA Immunization Activity is one way that the Division assesses quality of care received by SCHIP enrollees. GPRA is a CMS-sponsored multi-year initiative to improve immunization rates for two year olds. In September 1999, the Division submitted baseline information derived from its HEDIS 1998 Report on the immunization status of MassHealth two-year-olds enrolled in the PCC Plan and the Division's contracted MCOs. In January 2001, the Division submitted to CMS its interim measurement based on its HEDIS 2000 results.

HEDIS 2000 focused on measures selected from the Effectiveness of Care domain. Effectiveness of Care measures are intended to demonstrate the impact of health care delivered during the designated reporting period. The MassHealth HEDIS 2000 (Reporting Year 1999) Report was completed on January 24, 2001 and measures included Childhood Immunization Status.

The Division attempts to measure the rate of low birth weight babies born to MassHealth mothers. Since this data cannot be accurately measured from claims, a workgroup was convened to revise the Notification of Birth Forms. A field for birthweight was added to the form and providers were notified by a Bulletin in April 1999. Since its implementation in FY99 the Division has collected two years of data. Attempts to verify the preliminary data against a sample of PCC Plan newborn records did not yield reliable data due to incomplete maternal information on the newborn records. Therefore, birthweight data was collected as part of the PCC Plan HEDIS 2000 initiative. The data will be used to verify a sample of birthweights in the Notification of Births (NOB) database.

The Division uses its PCC Profile Reports to help PCCs identify areas for improvement, and to identify related improvement interventions. PCC Profile reports are provided for each PCC practice serving more than 200 PCC Plan members. In FY01, the Profile Report Improvement Project work group continued to meet weekly to discuss ongoing quality improvement for the report. To improve the timeliness of the Profile Report data, a Reminder Report was developed which included lists of members overdue for well child care visits. Members who appear on consecutive reports are shaded, highlighting members most in need of a particular service. Two Reminder Reports were distributed in FY01 and have been well received by the PCCs. Based on the feedback received by the Division, indications are the PCCs are using the Reminder Reports as practice improvement tools.

In the behavioral health arena, the Quality Improvement Council meets quarterly, and is comprised of representatives from the Division, Division of Mental Health (DMH), the Massachusetts Behavioral Health Partnership (MBHP also known as the Partnership) and representatives from consumer, family and clinical advisory councils. The Quality Improvement Council provides a forum at which to discuss high-level issues that cut across departmental and public/private sector lines. The topics discussed in FY01 included child and adolescent behavioral health appointment access and satisfaction surveys.

A Family Advisory Council meets monthly to engage in discussions of program information, helping monitor contractor performance with special emphasis placed on behavioral health care services provided to not only children but to families. This council is made up of family members of adults and children either biologically related, in a foster care arrangement or in an adoptive family. This group includes representatives from the Division, Department of Social Services (DSS), the Massachusetts Chapter of the National Alliance of the Mentally Ill, and the Parent/Professional Advisory League. Topics of discussion in FY01 included access to intermediate levels of care and outpatient treatment for “stuck” kids.

- C. What plans does your SCHIP program have for future monitoring/assessment of quality of care received by SCHIP enrollees? When will data be available?

In FY02, the Division will continue its quality improvement activities in support of the Division achieving its final GPRA goal of 80% of MassHealth-enrolled two-year olds being fully immunized. The Division will submit its final measurement to CMS once the HEDIS 2002 report has been completed.

During FY02 rates of low birth weight and very low birth weight will be collected and shared with PCC Plan providers, MCOs, and the PQIP workgroup.

SECTION 3. SUCCESSES AND BARRIERS

This section has been designed to allow you to report on successes in program design, planning, and implementation of your State plan, to identify barriers to program development and implementation, and to describe your approach to overcoming these barriers.

3.1 Please highlight successes and barriers you encountered during FFY 2001 in the following areas. Please report the approaches used to overcome barriers. Be as detailed and specific as possible.

Note: If there is nothing to highlight as a success or barrier, Please enter "NA" for not applicable.

A. Eligibility: N.A.

B. Outreach: See Section 2.4

C. Enrollment:

MassHealth total enrollment for children has increased from 393,318 on Sept 30, 2000 to 419,912 on Sept 30, 2001. Although our data shows a drop from 11/30/00 to 9/30/01 in SCHIP enrollment, preliminary review of this data shows that 75% of these children have remained enrolled in other MassHealth categories. The Division continues to work towards identifying their patterns of migration through the MassHealth caseload.

D. Retention/disenrollment:

In FY01, the Division contracted with CMER to evaluate the redetermination process. The goals of the evaluation were to assess the trend in non-response rates, determine the factors that may enhance or detract from the redetermination process through interviews, and compare Massachusetts's redetermination strategies and response rate to that of other states.

The household non-response rate to the renewal process has improved. In January 2000, the non-response rate was 30%. By March 2001 the non-response rate had dropped significantly to 17%. (Final report is in progress.)

E. Benefit structure: N.A.

F. Cost-sharing: N.A.

G. Delivery system: N.A.

H. Coordination with other programs:

The Division along with other state agencies has made a concerted effort to increase enrollment of uninsured children. For example, in FY01 the Division and the Department of Transitional Assistance (DTA) designed and planned the implementation of a joint application that assures all DTA applicants are automatically assessed for MassHealth eligibility, regardless of their eligibility for benefits through DTA.

Another example, which also focused on enrollment, is the Covering Kids program. Several joint initiatives have been undertaken as part of the Massachusetts Covering Kids initiative. See Section 2.4 for more detail.

The Division also collaborates with DPH by having a joint application and referring applicants who are not eligible for MassHealth to CMSP. CMSP provides access to primary care and preventive services for children and adolescents under age 19 not eligible for MassHealth.

The Division has worked with other groups to identify special populations in order to deliver appropriate care. The Division, working with state agencies and providers, helped to define a systematic approach to identify children with special health care needs within health care delivery systems. For example, the goal of the “PCC Plan Children with Special Health Care Needs (CSHCN)” initiative is to identify a group of children with special health care needs enrolled in the PCC Plan who may benefit from quality improvement (QI) intervention. Through New England SERVE, and in collaboration with Neighborhood Health Plan, Massachusetts General Hospital, and other providers, the Division explored different approaches for identifying these children within PCC Plan claims data.

- I. Crowd-out: N.A.
- J. Other: N.A.

SECTION 4: PROGRAM FINANCING

This section has been designed to collect program costs and anticipated expenditures.

- 4.1 **Please complete Table 4.1 to provide your budget for FFY 2001, your current fiscal year budget, and FFY 2002-projected budget. Please describe in narrative any details of your planned use of funds.**

Note: Federal Fiscal Year 2001 starts 10/1/00 and ends 9/30/01).

	Federal Fiscal Year 2001 costs	Federal Fiscal Year 2002	Federal Fiscal Year 2003
Benefit Costs			
Insurance payments (premium assistance payments)	\$943,000*	\$2,000,000**	\$2,200,000**
Managed care	\$28,632,828	\$27,692,308	\$31,436,281
per member/per month rate X # of eligibles			
Fee for Service	\$47,741,073	\$61,230,769	\$62,002,051
Total Benefit Costs			
(Offsetting beneficiary cost sharing payments)			
Net Benefit Costs	\$77,316,901	\$90,923,077	\$93,438,333
Administration Costs			
Personnel			
General administration			
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/marketing costs			
Other	\$2,142,603	\$2,307,692	\$2,589,369
Total Administration Costs	\$2,142,603	\$2,307,692	\$2,589,369
10% Administrative Cost Ceiling	\$7,731,690	\$9,092,307	\$9,343,833
Federal Share (multiplied by enhanced FMAP rate)	\$51,648,678	\$60,600,000	\$62,418,000
State Share	\$27,810,826	\$32,630,769	\$33,609,692
TOTAL PROGRAM COSTS	\$79,459,504	\$92,230,769	\$96,027,692

* Expenditures for FY01 premium assistance payments are estimates.

** Projected FY02 and FY03 premium assistance payments assumes approval of pending a State Plan Amendment (SPA) that would modify current Benchmark Benefit Level.

Note: Expenditures in the FY00 annual report reflected federal dollars only.

4.2 Please identify the total State expenditures for family coverage during Federal fiscal year 2001.

\$943,000 (note: this is the estimated amount spent on premium assistance payments for SCHIP children in FY01. This estimate includes Federal funds at 65% and State funds at 35%. Parents and other family members may not actually be eligible for MassHealth coverage, but become insured through ESI that the family now purchases with the help of the Division's premium assistance payments.)

4.3 What were the non-Federal sources of funds spent on your SCHIP program during FFY 2001?

- ☒ State appropriations
- ☐ County/local funds
- ☐ Employer contributions
- ☐ Foundation grants
- ☐ Private donations (such as United Way, sponsorship)
- ☐ Other (specify)

A. Do you anticipate any changes in the sources of the non-Federal share of plan expenditures.

No.

SECTION 5: SCHIP PROGRAM AT-A-GLANCE

This section has been designed to give the reader of your annual report some context and a quick glimpse of your SCHIP program.

5.1 To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. If you do not have a particular policy in-place and would like to comment why, please do. (Please report on initial application process/rules)

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Program Name	MassHealth	MassHealth
Provides presumptive eligibility for children	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, for whom and how long? For Children with self-declared family income $\leq 150\%$ of FPL for 60 days	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, for whom and how long? For Children with self-declared family income $>150\%$ but $\leq 200\%$ of FPL for 60 days
Provides retroactive eligibility	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, for whom and how long? All children, coverage begins 10 days prior to application	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, for whom and how long? All children, coverage begins 10 days prior to application
Makes eligibility determination	<input checked="" type="checkbox"/> State Medicaid eligibility staff <input type="checkbox"/> Contractor <input type="checkbox"/> Community-based organizations <input type="checkbox"/> Insurance agents <input type="checkbox"/> MCO staff <input type="checkbox"/> Other (<i>specify</i>)	<input checked="" type="checkbox"/> State Medicaid eligibility staff <input type="checkbox"/> Contractor <input type="checkbox"/> Community-based organizations <input type="checkbox"/> Insurance agents <input type="checkbox"/> MCO staff <input type="checkbox"/> Other (<i>specify</i>)
Average length of stay on program	Specify months For all MassHealth Members the mean number of days enrolled per year was greater than 350 (more than 11 months)	Specify months For all MassHealth Members the mean number of days enrolled per year was greater than 350 (more than 11 months)
Has joint application for Medicaid and SCHIP	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Has a mail-in application	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
Can apply for program over phone	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
Can apply for program over internet	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
Requires face-to-face interview during initial application	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
Requires child to be uninsured for a minimum amount of time prior to enrollment	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, specify number of months _____ What exemptions do you provide?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, specify number of months _____ What exemptions do you provide?
Provides period of continuous coverage <u>regardless of income changes</u>	<input checked="" type="checkbox"/> No (but certain children may receive an additional 12 months of coverage after an increase in income from earnings under TMA) <input type="checkbox"/> Yes, specify number of months _____ Explain circumstances when a child would lose eligibility during the time period	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, specify number of months _____ Explain circumstances when a child would lose eligibility during the time period
Imposes premiums or enrollment fees	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, how much? _____ Who Can Pay? <input type="checkbox"/> Employer <input type="checkbox"/> Family <input type="checkbox"/> Absent parent <input type="checkbox"/> Private donations/sponsorship <input checked="" type="checkbox"/> Other (anyone)	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes, how much? \$10 per child up to \$30 per month Who Can Pay? <input type="checkbox"/> Employer <input type="checkbox"/> Family <input type="checkbox"/> Absent parent <input type="checkbox"/> Private donations/sponsorship

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
		<u> X </u> Other (anyone)
Imposes copayments or coinsurance	<u> X </u> No <u> </u> Yes	<u> X </u> No <u> </u> Yes
Provides preprinted redetermination process	<u> X </u> No <u> </u> Yes, we send out form to family with their information precompleted and: <u> </u> ask for a signed confirmation that information is still correct <u> </u> do not request response unless income or other circumstances have changed	<u> X </u> No <u> </u> Yes, we send out form to family with their information and: <u> </u> ask for a signed confirmation that information is still correct <u> </u> do not request response unless income or other circumstances have changed

5.2 Please explain how the redetermination process differs from the initial application process.

The information required for redetermination is essentially the same information requested for the initial application process. An ERV form must be completed. The ERV is shorter than the MBR. The redetermination process is explained in Section 2.5.

SECTION 6: INCOME ELIGIBILITY

This section is designed to capture income eligibility information for your SCHIP program.

- 6.1 As of September 30, 2001, what was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group?** If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately. Please report the threshold after application of income disregards.

**Title XIX Child Poverty-related Groups or
Section 1931-whichever category is higher**

185 % of FPL for children under age 1
133 % of FPL for children aged 1-18 pursuant to State
Plan Amendment in August 2000.

Medicaid SCHIP Expansion

>185% [200% of FPL for children aged <1
>133% [150 % of FPL for children aged 1-5
>114% [150 % of FPL for children aged 6-14 (D.O.B. >
9/30/83)
>86% [150 % of FPL for children aged 14- <18 (D.O.B.
before 9/30/83)
0 % [150% of FPL for children age 18

Separate SCHIP Program (Family Assistance)

>150% [200% of FPL for children aged 1 [18

Other SCHIP program (CommonHealth— for disabled children)

>150% [200% of FPL for children aged 1 [18

- 6.2 As of September 30, 2001, what types and amounts of disregards and deductions does each program use to arrive at total countable income?** Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter "NA".

N.A.

Do rules differ for applicants and recipients (or between initial enrollment and redetermination)

 Yes X No

If yes, please report rules for applicants (initial enrollment).

Table 6.2			
	Title XIX Child Poverty- related Groups	Medicaid SCHIP Expansion	Separate SCHIP Program
Earnings	\$	\$	\$
Self-employment	\$	\$	\$
Alimony payments Received	\$	\$	\$
Paid	\$	\$	\$
Child support payments Received	\$	\$	\$
Paid	\$	\$	\$
Child care expenses	\$	\$	\$
Medical care expenses	\$	\$	\$
Gifts	\$	\$	\$
Other types of disregards/deductions (specify)	\$	\$	\$

6.3 For each program, do you use an asset test?

Title XIX Poverty-related Groups

☒ No ☐ Yes, specify countable or allowable level of asset test _____

Medicaid SCHIP Expansion program

☒ No ☐ Yes, specify countable or allowable level of asset test _____

Separate SCHIP program

☒ No ☐ Yes, specify countable or allowable level of asset test _____

Other SCHIP program _____

☒ No ☐ Yes, specify countable or allowable level of asset test _____

6.4 Have any of the eligibility rules changed since September 30, 2001?

☐ Yes ☒ No

SECTION 7: FUTURE PROGRAM CHANGES

This section has been designed to allow you to share recent or anticipated changes in your SCHIP program.

7.1 What changes have you made or are planning to make in your SCHIP program during FFY 2002 (10/1/01 through 9/30/02)? Please comment on why the changes are planned.

A. Family coverage NC

B. Employer sponsored insurance buy-in

A State Plan amendment is pending that, if approved, will change the Benchmark Benefit Level currently used for ESI from the HMO with the largest enrollment to the Basic Benefit Level approved for ESI under the 1115 Demonstration Waiver. This will allow the state to claim enhanced FFP under SCHIP for several children currently receiving Family Assistance through the 1115 Demonstration. There is no change in benefit for the child.

C. 1115 waiver NC

D. Eligibility including presumptive and continuous eligibility NC

E. Outreach NC

F. Enrollment/redetermination process NC

G. Contracting NC

H. Other NC

Table 1.3			
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methods, etc.)	
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN			
Expand access to health coverage for low-income children in the Commonwealth.	Reduce the number of uninsured children in the Commonwealth.	Data Sources: '00 U.S. Census Bureau and DHCFP '00 Data.	
		Methodology: Decrease the ratio of uninsured children to insured children 1:9.	
		Numerator:	
		Measure 1) Number of uninsured children in the state	
		Source	DHCFP
		Number of uninsured children	42,000
		Percent of uninsured children	2.1%
		Measure 2) Number of insured children in the state	
		Source	DHCFP
		Number of insured children	1,900,000
		Percent of insured children	97.9%
		Denominator: Measure 1 and 2) Total number of children in the state	
		U.S. Census 2000** Total number of children 0-17	1,942,000
		Progress Summary: As reported in last year's report, two key factors have influenced the insurance status of Massachusetts' residents over time, and both have resulted in a decrease in the number of uninsured children. The survey conducted by DHCFP found that the number of uninsured children (≤ 18) in the state dropped from 5.8% in 1999 to 2.1% in 2000. NSAF found that the number of uninsured children dropped from 13.8% in 1997 to 6.5% in 1999, and that for low income children, NSAF found the rate of uninsured children dropped from 13.8% in 1997 to 6.5% in 1999.	
		*using U.S. Census 2000 children 0-17	
**DHCFP survey includes children 18 years and under, the U.S. Census includes children 17 years and under.			

Table 1.3

(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, and progress)
OBJECTIVES RELATED TO SCHIP ENROLLMENT		
Develop programs to expand health coverage while maximizing employer-sponsored health insurance to low income children.	Implement MassHealth Family Assistance in state fiscal year 1998.	<p>Data Sources: <i>Premium Assistance Summary by Plan Enrollment</i></p> <p>Methodology:</p> <p><u>Measure 1:</u> Comparison of children enrolled in Family Assistance Premium with those enrolled in Family Assistance Direct Coverage (FA/DC).</p> <p><u>Measure 2:</u> Comparison of those in FA/PA who came in insured with those uninsured.</p> <p><u>Measure 3:</u> Comparison of those in FA/PA who came in uninsured with access to Title XXI access requirements with those who came in uninsured with access to 1115 Waiver requirements.</p> <p>Numerator: *</p> <p><u>Measure 1:</u> Children in FA/PA as of September 30, 2001 = 3776</p> <p><u>Measure 2:</u> Children in FA/PA who came in uninsured as of September 30, 2001 = 1431</p> <p><u>Measure 3:</u> Children in FA/PA who came in uninsured and met Title XXI requirements as of September 30, 2001 = 43.</p> <p>Denominator: *</p> <p><u>Measure 1:</u> Children in FA/DC as of September 30, 2001 = 14,462.</p> <p><u>Measure 2:</u> Children in FA/PA who came in insured as of September 30, 2001 = 2345</p> <p><u>Measure 3:</u> Children in FA/PA who came in uninsured and met 1115 Waiver requirements as of September 30, 2001 = 1388</p> <p>Progress Summary: *</p> <p><u>Measure 1:</u> 3776 children are in FA/PA as of 09/30/01. An additional 14,462 children are in FA/DC. Nearly one quarter of children in Family Assistance are in PA.</p> <p><u>Measure 2:</u> 1431 children in FA/PA came in uninsured. 2345 children in FA/PA came in insured as of 09/28/01. Approximately 2/3 of children in FA/PA come in insured, while 1/3 come in uninsured.</p> <p><u>Measure 3:</u> 43 children in FA/PA met Title XXI requirements for access to ESI. 43 children in FA/PA met the Title XIX 1115 Waiver requirements for access to ESI. The remaining 2302 children who came in uninsured are enrolled in FA/PA through the 1115 waiver.</p> <p>*note: In the 2000 SCHIP annual report figures from November 30, 2000</p>

Table 1.3

(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, etc.)
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OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT

Improve the efficiency of the eligibility determination process.	<p><u>Performance Goal A:</u> Develop a streamlined eligibility process by eliminating certain verifications.</p> <p><u>Performance Goal B:</u> Develop a fully automated eligibility determination process.</p> <p>Goals A and B have been completed.</p>	<p>Data Sources: Goal A: MassHealth Benefit Request (MBR) application; Goal B: MA21 system</p> <p>Methodology: Determine 90% of applicants eligibility status within 15 days of receipt of a completed MBR</p> <p>Numerator: Number of applicants for whom eligibility status is determined</p> <p>Denominator: Number of MBR applications filed</p> <p>Progress Summary: Eligibility is determined, within 15 days, for all applicants who submit a complete MBR. (During FY01, eligibility on average was determined within 3 days of receipt of a completed MBR). In FY01 the Division processed 108,569 applications (including new, re-applications, and maintenance) through its MA21 automated eligibility system.</p>
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OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)

N.A.		<p>Data Sources:</p> <p>Methodology:</p> <p>Progress Summary:</p>
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Table 1.3

(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, etc.)
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OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)

<p>Improve the health status and well-being of children enrolled in MassHealth direct coverage programs, which includes the Primary Care Clinician (PCC) and Managed Care Organizations (MCO) plans.</p>	<p><u>Performance Goal A:</u> <i>Improve the delivery of well child care by measuring the number of well child visits and implementing improvement activities as appropriate.</i></p> <p><u>Performance Goal B:</u> Improve the immunization rates by measuring the rate of immunization administration and implementing improvement activities as appropriate.</p>	<p>Data Sources: HEDIS, Summary Analysis of Clinical I Clinician (PCC) Plan Profile Reports, CMS 416 Report, Methodology: <u>Performance Goal A:</u> 1) The PCC Profil Project work group continued to meet weekly to discuss improvement for the report, which includes a well-child improve the timeliness of the Profile Report data, a Rem developed which provides PCCs with lists of panel mem child care visits. 2) Participation in the Massachusetts H Partnership, Inc. (MHQP) (MHQP is a broad-based coal providers and health plans.): development and distributi Guidelines: Pediatric Preventive Care Recommendation Division’s EPSDT regulations and Medical Protocol and Updated the Well-Child Care Visit Schedule card for me to all MassHealth providers delivering services to childr regulation update, an updated EPSDT Billing Guide, an Sheet, an alert about updated DPH childhood lead screen among other tools for providers. 6) Produced a brochure up Healthy,” in multiple languages to remind members a visit schedule and the importance of immunizations. 7) I an article regarding the EPSDT regulation update to the the Massachusetts Chapter of the American Academy of Continued work on the MassHealth Adolescent Anticipa Awareness Campaign (MAGPAC), an effort to increase child care visit rates. 9) As part of the MAGPAC projec graduate students at Emerson College’s Health Commu perform a literature review for articles pertaining to ado care services. 10) As part of the MAGPAC project, enlis focus group administration to oversee five focus groups areas to discuss with MassHealth adolescents their view care services.</p>
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		<p><u>Numerator</u>: number of MassHealth continuously enrolled well-child visit in accordance with the EPSDT Medical Schedule</p> <p><u>Denominator</u>: number of MassHealth continuously enrolled</p> <p>Progress Summary:</p> <p>Performance Goal A: FFY00 CMS 416 EPSDT Requirement of 70% (participation ratio compares the number of adolescents who were due to receive a visit within 12 months with the number who actually received a visit.)</p> <p>Methodology: Performance Goal B: 1) Participation in the Government Performance Results Act (GPRA) Immunization initiative to improve immunization rates for 2 year olds. 2) The Summer of Shots ShotClock, a newsletter published by the Massachusetts Department of Public Health, included an article submitted by the Division titled, "Massachusetts Division of Medical Assistance Continues to Improve Immunization Efforts." 3) The Division entered into an agreement with the Massachusetts Immunization Program (MIP) so that the results of its provider immunization assessments with the Division can be used by the Division to initiate immunization quality improvement projects. 4) The Division has participated in the MHQP endorsement of the Massachusetts Immunization Guidelines. MHQP distributed the immunization recommended childhood schedule along with the distribution of the Preventive Care Recommendations. 5) Oversaw the development of an article targeting providers and focusing on immunization in childhood immunization. The article, jointly written by the Division and MIP, will be printed and mailed to providers in calendar year 2000. A brochure, "Help your child grow up Healthy," in multiple languages, will be distributed to members about the well-child care visit schedule and the immunization schedule.</p> <p><u>Numerator</u>: # of children received 4 DTP/DtaP, 3 Polio, 1 Hib, 1 Hep B, 1 Hib.</p> <p><u>Denominator</u>: # of children who turned 2 in 1999, continuing on the MMR or PPC Plan for 12 months preceding 2nd birthday, with enrollment up to 45 days.</p> <p>Progress Summary: From the MassHealth Managed Care Program, the MassHealth mean for the combination of vaccines 4 DTP/DtaP, 3 Polio, 1 Hib, and 3 Hep B was 69.1%, up from 64.3% from</p>
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Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data source period, etc.)
OTHER OBJECTIVES		
Coordinate with other health care programs – specifically the state funded CMSP, to create a seamless system for low income children in need of health care.	<p><u>Performance Goal A:</u> Develop single application for both MassHealth and CMSP.</p> <p><u>Performance Goal B:</u> Enroll all CMSP members eligible for MassHealth prior to August 24, 1998.</p> <p><u>This goal has been completed.</u></p>	As noted in last year's report, both Performance Goal A and B have been met. A single application form is in use for both CMSP. 70% of CMSP members eligible for MassHealth prior to August 24, 1998 were enrolled in MassHealth in a coordinated effort between MassHealth and CMSP. An additional 5500 children on CMSP were ineligible for MassHealth other than MassHealth Limited because of immigration status. An additional 5500 children on CMSP who were eligible for MassHealth benefits and other factors are estimated to have been enrolled.

Appendix

Attachments

- Attachment A: Executive Summary of the Family Assistance Direct Coverage and Presumptive Eligibility Evaluation Findings
- Attachment B: FY00 Outreach Mini-Grant Project Executive Report
- Attachment C: 2000 - 2001 MassHealth Member Survey instruments